C. Payments in items A and B are limited by the Medicare upper payment limits for non-state, government-owned or operated nursing facilities.

SECTION 19.090 **Disaster-related provisions.**

A. Notwithstanding a provision to the contrary, a facility may receive payments for expenses specifically incurred due to a disaster. Payments will be based on actual documented costs for the period during which the costs were incurred, and will be paid as an add-on to the facility's payment rate, or as a lump sum payment. The actual costs paid will be reported on the next annual cost report as non-allowable costs, in order to avoid duplicate payment. Costs submitted for payments will be subject to review and approval by the Department. The Department's decision is final and not subject to appeal. Costs not paid in this manner may be claims on the subsequent cost report for inclusion in the facility's payment rate.

B. For transfers of less than 60 days, the rates continue to apply for evacuated facilities and residents are not counted as admissions to facilities that admit them. The resident days related to the placement of such residents who continued to be billed under an evacuated facility's provider number are not counted in the cost report submitted to calculate rates, and the additional expenditures are considered non-allowable costs for facilities that admit victims.

C. For transfers of 60 days or more, a formal discharge/admission process must be completed, so that the resident becomes a resident of the receiving facility.

D. When a person is admitted to a facility from the community, the resident assessment requirement in Section 14.010 is waived. If the resident has resided in the facility for 60 days or more, the facility must comply with Section 14.010 as soon as possible.

SECTION 19.100 **Bed layaway and delicensure.**

A. For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under Sections 1.000 through 20.000 that places beds on layaway will, for purposes of application of the downsizing incentive in Section 15.040, item G, and calculation of the rental per diem, have the beds given the same effect as if the beds had been delicensed so long as they remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Section 15.110. The property payment rate increase is effective the first day of the month following the month in which the layaway of the beds becomes effective under state law.

B. For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary in Section 21.000, a nursing facility reimbursed under Section 21.000 that places beds on layaway is, for so long as the beds remain on layaway, allowed to:

(1) Aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system in Section 21.000;

(2) Retain or change the facility's single bed election for use in calculating capacity days under Section 15.110; and

(3) Establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

C. The Department will increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and subitems (1), (2), and (3). If a facility reimbursed under Section 21.000 completes a moratorium exception project after its base year, the base year property rate is the moratorium project property rate. The base year rate is inflated by the factors in Section 21.060, items C through F. The property payment rate increase is effective the first day of the month following the month in which the layaway of the beds becomes effective.

D. If a nursing facility removes a bed from layaway status in accordance with state law, the Department will establish capacity days based on the number of licensed and certified beds in the facility not on layaway and will reduce the nursing facility's property payment rate in accordance with item B.

E. For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under Section 21.000, a nursing facility reimbursed under that section, with delicensed beds after July 1, 2000, by giving notice of the delicensure to the Department of Health according to the notice requirements in state law, is allowed to:

(1) Aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) Retain or change the facility's single bed election for use in calculating capacity days under Section 15.110; and

(3) Establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The Department will increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and subitems (1), (2), and (3). If a facility reimbursed under Section 21.000 completes a moratorium exception project after its base year, the base year property rate is the moratorium project property rate. The base year rate is inflated by the factors in Section 21.060, items C through F. The property payment rate increase is effective the first day of the month following the month in which the delicensure of the beds becomes effective.

F. For nursing facilities reimbursed pursuant to Sections 1.000 to 20.000 or Section 21.000, any beds placed on layaway are not included in calculating facility occupancy as it pertains to leave days.

G. For nursing facilities reimbursed pursuant to Sections 1.000 to 20.000 or Section 21.000, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

H. A nursing facility receiving a rate adjustment as a result of this section must not increase nursing facility rates for private pay residents until it notifies the residents, or the persons responsible for payment of the increase, in writing 30 days before the increase takes effect. No notice is required if a rate increase reflects a necessary change in a resident's level of care.

I. A facility that does not utilize the space made available as a result of bed layaway or delicensure under this section to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this section reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

SECTION 20.000 ANCILLARY SERVICES

SECTION 20.010 **Setting payment and monitoring use of therapy services.** At the option of the nursing facility, payment for ancillary materials and services otherwise covered under the plan may be made to either the nursing facility in the operating cost per diem, to the vendor of ancillary services, or to the nursing facility outside of the operating cost per diem. The avoidance of double payments shall be made through audits and adjustments to the nursing facility's annual cost report. The Department will also determine if the materials and services are cost effective and as would be incurred by a prudent and cost-conscious buyer. Therapy services provided to a recipient must be medically necessary and appropriate to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician cannot provide adequate medical necessity justification, the Department may recover or disallow the payment for the services and may require prior authorization for therapy services or may impose administrative sanctions to limit the provider participation in the medical assistance program.

SECTION 20.020 **Certification that treatment is appropriate.** The therapist who provides or supervises the provision of therapy services must certify in writing that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient every 30 days. The Department shall utilize a peer review program to make recommendations regarding the medical necessity of services provided.

SECTION 21.000 CONTRACTUAL ALTERNATIVE PAYMENT RATES AFTER AUGUST 1, 1995

SECTION 21.010 **Contractual alternative payment rate.** A nursing facility may apply to be paid a contractual alternative payment rate instead of the cost-based payment rate established under Sections 1.000 to 20.000. A nursing facility selected to receive an alternative payment rate must enter into a contract with the state. Payment rates and procedures for facilities selected to receive an alternative payment rate are determined and governed by this section and by the terms of the contract. Different contract terms for different nursing facilities may be negotiated.

SECTION 21.020 **Requests for proposals.**

A. At least twice annually the Department will publish a request for proposals to provide nursing facility services according to this section. All proposals must be responded to in a timely manner.

B. Any proposal may be rejected if, in the judgment of the Department, a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

SECTION 21.030 **Proposal requirements.**

A. In issuing the request for proposals, the Department may develop reasonable requirements which, in the judgment of the Department, are necessary to protect residents or ensure that the contractual alternative payment demonstration project furthers the interest of the state of Minnesota.

B. The request for proposals may include, but need not be limited to, the following:

(1) A requirement that a nursing facility make reasonable efforts to maximize Medicare payments on behalf of eligible residents;

(2) Requirements designed to prevent inappropriate or illegal discrimination against residents enrolled in the medical assistance program as compared to private paying residents;

(3) Requirements designed to ensure that admissions to a nursing facility are appropriate and that reasonable efforts are made to place residents in home and community-based settings when appropriate;

(4) A requirement to agree to participate in a project to develop data collection systems and outcome-based standards for managed care contracting for long-term care services;

(5) A requirement that contractors agree to maintain Medicare cost reports and to submit them to the Department upon request or at times specified by the Department;

(6) A requirement for demonstrated willingness and ability to develop and maintain data collection and retrieval systems to be used in measuring outcomes; and

(7) A requirement to provide all information and assurances required by the terms and conditions of federal approval.

SECTION 21.040 **Selection process.**

A. The number of proposals that can be adequately supported with available state resources, as determined by the Department, may be accepted.

B. The Department may accept proposals from a single nursing facility or from a group of facilities through a managing entity.

C. The Department will seek to ensure that nursing facilities under contract are located in all geographic areas of the state.

D. In addition to the information and assurances contained in the submitted proposals, the Department may consider the following in determining whether to accept or deny a proposal:

(1) The facility's history of compliance with federal and state laws and rules, except that a facility deemed by the Department to be in substantial compliance with federal and state laws and rules is eligible to respond to a request for proposal. A facility's compliance history is not the sole determining factor in situations where the facility has been sold and the new owners have submitted a proposal;

(2) Whether the facility has a record of excessive licensure fines or sanctions or fraudulent cost reports;

(3) The facility's financial history and solvency; and

(4) Other factors identified by the Department that it deems relevant to a determination that a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

E. If the Department rejects the proposal of a nursing facility, it will provide written notice to the facility of the reason for the rejection, including the factors and evidence upon which the rejection was based.

SECTION 21.050 **Duration and termination of contracts.**

A. Contracts with nursing facilities may be executed beginning November 1, 1995.

B. All contracts entered into under this section are for a term of one year.

C. Either party may terminate a contract at any time without cause by providing 90 calendar days advance written notice to the other party. The decision to terminate a contract is not appealable.

D. The contract will be renegotiated for additional one-year terms, unless either party provides written notice of termination. The provisions of the contract will be renegotiated annually by the parties before the expiration date of the contract.

E. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

F. If a nursing facility fails to comply with the terms of a contract, the Department will provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance.

G. If the facility fails to come into compliance or to remain in compliance, the Department may terminate the contract. If a contract is terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was terminated, but in all other respects the provisions of this section do not apply to that facility effective as of the date the contract is terminated.

H. The contract must contain a provision governing the transition back to the cost-based reimbursement system established under Sections 1.000 to 20.000.

SECTION 21.060 **Alternate rates for nursing facilities.**

For nursing facilities that have their payment rates determined pursuant to this section rather than pursuant to Sections 1.000 to 20.000, a rate must be established under this section as follows:

A. The nursing facility must enter into a written contract with the Department;

B. A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the same payment rate as established for the facility under Sections 1.000 to 20.000;

C. A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment as provided in items D and E, and an adjustment to include the cost of any increase in Minnesota Department of Health licensing fees for the facility taking effect on or after July 1, 2001.

D. The index for the inflation adjustment must be based on the change in the

Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the rate year.

E. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

F. For the rate years beginning July 1, 1999, July 1, 2000, July 1, 2001, and July 1, 2002, items C, D, and E apply only to the property related payment rate, except that adjustments to include the cost of any increase in Minnesota Department of Health licensing fees taking effect on or after July 1, 2001, shall be provided. In determining the amount of the property related payment rate adjustment under items C, D and E, the Department must determine the proportion of the nursing facility's rates that are property related based on the facility's most recent cost report.

SECTION 21.065 **Facility rate increases beginning July 1, 1999.** For the rate year beginning July 1, 1999, a nursing facility's case mix rate is divided into the following components: compensation operating rate, non-compensation operating rate, property rate and other-components rate. The compensation and non-compensation operating rates are increased by the percentages in Section 11.049, item B, subitem (1), respectively. The property related payment rate is increased as described in Section 21.060, item F. The other-components rate is not increased from the June 30, 1999 rate.

A. A nursing facility in Becker county licensed for 102 beds on September 30, 1998 receives the following increases:

(1) $1.30 in its case mix class A payment rate;

(2) $1.33 in its case mix class B payment rate;

(3) $1.36 in its case mix class C payment rate;

(4) $1.39 in its case mix class D payment rate:

(5) $1.42 in its case mix class E and F payment rate;

(6) $1.45 in its case mix class G payment rate;

(7) $1.49 in its case mix class H payment rate;

(8) $1.51 in its case mix class I payment rate;

(9) $1.54 in its case mix class J payment rate; and

(10) $1.59 in its case mix class K payment rate;

B. A nursing facility in Chisago county licensed for 101 beds on September 30, 1998 receives an increase of $3.67 in each case mix payment rate:

C. A nursing facility in Canby, licensed for 75 beds will have its property-related per diem rate increased by $1.21. This increase will be recognized in the facility's contract payment rate under this section.

D. A nursing facility in Golden Valley with all its beds licensed to provide residential rehabilitative services to physically handicapped young adults has the payment rate computed according to this section increased by $14.83; and

E. A county-owned 130-bed nursing facility in Park Rapids has its per diem contract payment rate increased by $1.02 for costs related to compliance with comparable worth requirements.

SECTION 21.066 **Facility rate increases beginning July 1, 2000.** For the rate year beginning July 1, 2000, nursing facilities with an average operating rate as described in items A through F receive the rate increases indicated. "Average operating rate" means the average of the eleven (A-K) case mix operating rates. The increases are added following the determination under Section 11.050 of the payment rate for the rate year beginning July 1, 2000, and will be included in the nursing facilities' total payment rates for the purposes of determining future rates under this attachment to the State plan.

A. Nursing facilities with an average operating rate of $110.769 receive an operating cost per diem increase of 5.9 percent, provided that the facilities delicense, decertify, or place on layaway status, if that status is otherwise permitted by law, 70 beds.

B. Nursing facilities with an average operating rate of $79.107 receive an increase of $1.54 in each case mix payment rate.

C. Nursing facilities with an average operating rate of $80.267 receive an increase in their case mix resident class A payment of $3.78, and an increase in their payment rate for all other case mix classes of that amount multiplied by the class weight for that case mix class established in Section 13.030.

D. Nursing facilities with an average operating rate of $94.987 receive an increase of $2.03 in each case mix payment rate to be used for employee wage and benefit enhancements.

E. Nursing facilities with an average operating rate of $82.369 have their operating cost per diem increased by the following amounts:

(1) case mix class A, $1.16;

(2) case mix class B, $1.50;

(3) case mix class C, $1.89;

(4) case mix class D, $2.26;

(5) case mix class E, $2.63;

(6) case mix class F, $2.65;

(7) case mix class G, $2.96;

(8) case mix class H, $3.55;

(9) case mix class I, $3.76;

(10) case mix class J, $4.08; and

(11) case mix class K, $4.76.

F. Nursing facilities with an average operating rate of $95.974 that decertified 22 beds in calendar year 1999 have their property-related per diem payment rate increased by $1.59.

SECTION 21.067 **Facility rate increases beginning July 1, 2001.**

A. For the rate year beginning July 1, 2001, the Department will provide an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001 include the adjustment in Section 11.070.

B. For rate years beginning on or after July 1, 2001 and for admissions occurring on or after July 1, 2001, the total payment rate for the first 90 paid days after admission is:

(1) for the first 30 paid days, the rate is 120 percent of the facility's medical assistance rate for each case mix class; and

(2) for the next 60 paid days after the first 30 paid days, the rate is 110 percent of the facility's medical assistance rate for each case mix class.

C. For rate years beginning on or after July 1, 2001 and for admissions occurring on or after July 1, 2001, beginning with the 91st paid day after admission, the payment rate is the rate otherwise determined under this Section.

D. For the rate year beginning July 1, 2001, the Department will adjust the operating payment rates for low-rate facilities. For each case mix level, if the amount computed under item A is less than the amount of the operating payment rate target level for July 1, 2001, below, the Department will make available the lesser of the amount of the operating payment rate target level for July 1, 2001, or an increase of ten percent over the rate in effect on June 30, 2001, as an adjustment to the operating payment rate. For the purposes of this item,

facilities are considered metro if they are located in Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, or Washington counties; or in the cities of Moorhead or Brekenridge; or in St. Louis county, north of Toivola and south of Cook; or in Itasca county, east of a north south line two miles west of Grand Rapids.

Operating Payment Rate Target Level for July 1, 2001

Case Mix Classification	Metro	Nonmetro
A	$76.00	$68.13
B	$83.40	$74.46
C	$91.67	$81.63
D	$99.51	$88.04
E	$107.46	$94.87
F	$107.96	$95.29
G	$114.67	$100.98
H	$126.99	$111.31
I	$131.34	$115.06
J	$138.34	$120.85
K	$152.26	$133.10

E. For the rate year beginning July 1, 2001, two-thirds of the money resulting from the rate adjustment under item A and one-half of the money resulting from the rate adjustment under items B through D must be used to increase the wages and benefits and pay associated costs of all employees except management fees, the administrator, and central office staff.

(1) Money received by a facility resulting from the rate adjustments under items A through D must be used only for wage and benefit increases implemented on or after July 1, 2001.

(2) A facility may apply for the portions of the rate adjustments under this item. The application must be made to the Department and contain a plan by which the facility will distribute the funds to its employees. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan, if the agreement is finalized after June 30, 2001.

(a) The Department will review the plan to ensure that the rate adjustments are used as required in this item.

(b) To be eligible, a facility must submit its plan for the wage and benefit distribution by December 31, 2001. If a facility's plan for wage and benefit distribution is effective for its employees after July 1, 2001, the portion of the rate adjustments are effective the same date as its plan.

(3) A hospital-attached facility may include costs in its distribution plan for wages and benefits and associated costs of employees in that organization's shared services departments, provided that the facility and the hospital share common ownership and adjustments for hospital services using the diagnostic-related grouping payment rates per admission under Medicare are less than three percent during the 12 months before July 1, 2001. If a hospital-attached facility meets these qualifications, the difference between the rate adjustments approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-attached facility's plan regardless of whether the use of the funds is shown as being attributable to employee hours worked in the facility or employee hours worked in the hospital.

F. Notwithstanding Sections 1.020 and 17.020, upon the request of a facility, the Department may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the rate adjustments allowable under items A through D. Until the rate is finalized, the Department will require any amounts collected, which must be used as provided in this item, to be placed in an escrow account established for this purpose with a financial institution that provides deposit insurance. The Department shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final rate are repaid to the private-pay residents with interest.

G. For rate years beginning on or after July 1, 2001, in calculating a facility's operating cost per diem for the purposes of constructing an array, determining a median, or otherwise performing a statistical measure of facility payment rates to be used to determine future rate increases, the Department will exclude adjustments for raw food costs under Section 8.020, item B, that are related to providing special diets based on religious beliefs.

H. For the rate year beginning July 1, 2001, facilities that changed their bed licensure from board and care beds to nursing home beds must have the additional cost of surcharge included in their rate. The increase is added following the determination of the payment rate for the rate year beginning July 1, 2001, and is included in the facility's total payment rates for the purposes of determining future rates.

I. For the rate year beginning July 1, 2001, non-profit facilities in the county with the fewest beds per 1000 for age 65 and over that are not accepting beds from another closing non-profit facility receive a total increase of $10 in each case mix rate, as a result of increases provided under this item and item D. The increases under this item are added before the determination under item D, of the payment rate for the July 1, 2001 rate year, and are included in the facility's total payment ate for purposes of determining future rates through June 30, 2004.

SECTION 21.068 **Facility rate increases beginning January 1, 2002.** For the rate period from January 1, 2002 through June 30, 2002, facilities that went from non-profit to for-profit status in 2000 receive an increase of $2.54 in each case mix payment rate to offset property tax payments due as a result of the facility's conversion from nonprofit to for-profit status. The increase will be added following the determination of the payment rate for the rate year beginning July 1, 2001, and will be included in a facility's total payment rates for the purposes of determining future rates.

SECTION 21.069 **Facility rate increases beginning July 1, 2002.**

A. For the rate year beginning July 1, 2002, the Department will provide an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001 include the adjustment in Section 11.070.

B. For the rate year beginning July 1, 2002, the Department will adjust the operating payment rates for low-rate facilities. For each case mix level, if the amount computed under items A is less than the amount of the operating payment rate target level for July 1, 2002, below, the Department will make available the lesser of the operating payment rate target level for July 1, 2002, or an increase of ten percent over the rate in effect on June 30, 2002, as an adjustment to the operating payment rate. For the purposes of this item, facilities are considered metro if they meet the requirements in Section 21.067, item D.

Operating Payment Rate Target Level for July 1, 2002

Case Mix Classification	Metro	Nonmetro
A	$78.28	$70.51
B	$85.91	$77.16
C	$94.42	$84.62
D	$102.50	$91.42
E	$110.68	$98.40
F	$111.20	$98.84
G	$118.11	$104.77
H	$130.80	$115.64
I	$135.38	$119.50
J	$142.49	$125.38
K	$156.85	$137.77

C. For the rate year beginning July 1, 2002, two-thirds of the money resulting from the rate adjustment under item A, and one-half of the money resulting from the rate adjustment under Section 21.067, items B and C and item B of this Section, must be used to increase the wages and benefits and pay associated costs of all employees except management fees, the administrator, and central office staff.

(1) Money received by a facility resulting from the rate adjustments under item A, Section 21.067, items B and C and item B of this Section must be used only for wage and benefit increases implemented on or after July 1, 2002.

(2) A facility may apply for the portions of the rate adjustments under this item. The application must be made to the Department and contain a plan by which the facility will distribute the funds to its employees. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan, if the agreement is finalized after the date of enactment of all increases for the rate year.

(a) The Department will review the plan to ensure that the rate adjustments are used as required in this item.